

**National Association of Surety Bond Producers  
to the Special Committee on Aging  
of the United States Senate  
regarding  
Regulations Requiring Surety Bonds  
from Home Health Agencies  
Participating in the Medicare and Medicaid Programs  
as promulgated by the  
Health Care Financing Administration  
of the U. S. Department of Health and Human Services**

*Submitted by  
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*Statement of the National Association of Surety Bond Producers (NASBP) to the United States  
Senate Special Committee on Aging  
regarding the requirement for surety bonds from home health agencies  
participating in the Medicare and Medicaid programs  
as promulgated by the Health Care Financing Administration (HCFA)  
of the U. S. Department of Health and Human Services*

Mr. Chairman and distinguished Members of the Senate Special Committee on Aging, I would like to thank you for giving the National Association of Surety Bond Producers (NASBP) the opportunity to share our concerns on the regulations recently promulgated by the Health Care Finance Administration (HCFA) requiring surety bonds from home health agencies participating in the Medicare and Medicaid programs. I am James C. Pateidl and currently serve as third vice president of NASBP as well as executive vice president of The Lockton Companies in Kansas City, Missouri.

The National Association of Surety Bond Producers is an organization of independent agencies and brokerage firms that specialize in surety bonding for business and industry. NASBP members are responsible for producing over 70 percent of the contract surety bonds written in the United States annually and a significant portion of all other kinds of surety bonds as well.

The first five years of my surety career were spent as an underwriter for The Travelers Indemnity Company, then and now, one of the top ten writers of surety bonds in the United States. For the last 25

years, I have served as the manager of the surety operations for a private insurance and bonding broker in Kansas City. The Lockton Companies is ranked as the largest privately owned commercial insurance agency in the United States. Bonding was our foundation when the company began 30 years ago, and remains as one of our leading areas of expertise.

Without reservation, we wholeheartedly endorse the efforts of Congress and HCFA in addressing the problem of fraud in the Medicare system. However, I am concerned that the means by which HCFA proposes to use the surety industry to address this problem will lead to a severe and unreasonable hardship on small business in the home health care profession. Accordingly, I wish to direct my comments more towards the economic impact of HCFA's regulations rather than the specific contents and language of the regulations.

First, however, I would like to begin by making a brief statement regarding the nature of a surety bond, in and of itself.

Following the release of the original HCFA regulations, several health associations had informed HCFA of either the difficulty of "...obtaining the collateral to qualify for the bond", or they made suggestions such as, "... use an escrow account in lieu of a bond" and "...accept and hold U. S. Savings Bonds to secure the collection of overpayments. Candidly, none of these suggestions have anything to do with the elimination of fraud. However, the comments are right on target when describing the nature of the bond obligation as stipulated in the HCFA regulations. Section II, Paragraph C of the HCFA regulations provides this definition of a "surety bond"

***The "surety bond" under this rule with comment period is an instrument obtained by an HHA from a surety company in which the surety company, acting as a surety, guarantees that it will be responsible for unrecovered debts owed to us by an HHA.***

**Clearly, and by definition under the proposed regulations, the surety bond stands, in lieu of cash collateral, to secure the repayment of "overpayments" and other "debt" as defined by HCFA. Was this the intent of Congress when passing the Balanced Budget Act of 1997?**

Having established the nature of the bond obligation, please recognize that a surety bond is an extension of credit, not unlike an irrevocable letter of credit which would be obtained from a bank. A surety bond cannot simply be bound or purchased like many other forms of insurance. The principal on a bond must undergo prequalification by the surety and be judged as an acceptable risk for the credit involved, before a bond will be executed.

The complaints that were made against the original bond requirements contained in the regulations were not lodged against the concept of using the surety industry to assist in the clean up of fraud in Medicare. The complaints were directed against the means by which HCFA is using the surety industry. By making the bond requirement a very strict, very large and very onerous financial guarantee, **HCFA has forced the home health care industry into a position where they must now qualify for a substantial credit undertaking.**

**Can small business qualify for this type of credit?** This question has to be answered before any criticisms or recommendations regarding the regulations can be understood. As I read the comments under Section VII (Regulatory Impact Analysis) of HCFA's January 5, 1998, rule, I cannot agree with some of the conclusions drawn. Without giving any consideration to the surety industry, I believe that basic reasoning supports the conclusion that these regulations will have a major impact on small business.

To fully understand our position, we have to look at some basic facts surrounding the home health care industry:

- Medicare payments are a reimbursement of approved costs.
- Efficiencies that result in lowering the cost of the delivery of home health care are returned to Medicare in the form of overpayments.
- Medicare payments are subject to a cap, establishing a maximum amount that may be received for defined home health procedures.
- Medicare payments are processed for HHA's on a weekly, and sometimes daily basis.
- Consider the impact these facts, inherent to the Medicare process, have on any business operation:
  - If not by design, then certainly by practice, the Medicare payment system has not allowed independent home health agencies to make and retain any meaningful level of profits.
  - To offset the obvious problems of cash flow that the lack of retained capital presents to a company, the Medicare payment process allows for weekly and even daily pay requests.

**The net effect of this practice has been to create an industry that has no need for professional financial reporting. Consequently, the average independent practitioner in home health care has neither the resources nor the tools allowing them the capacity to go to credit institutions, such as banks and bonding companies, to request a credit facility.**

Under the HCFA interpretation of the Regulatory Flexibility Act, those HHA's generating Medicare receipts of \$5,000,000 and less are considered "small entities". I would carry that one step further and call them small businesses as well. With that, I find the chart on page 304 of the regulations to be quite enlightening:

**Of 9,444 HHA's, 7,958 are classified as "small entities", by this definition. That leads me to conclude that over 84% of the home health agency distribution system is serviced by "small business".** In proportional terms, this has the potential of being a huge problem for the distribution of home health care services, which has a direct bearing on the welfare of the aged.

I hope that I have given you a realistic perspective of the home health care industry. It is from this perspective and foundation that I would like to now look at the nature of the HCFA surety bond obligation.

Through these regulations (even when amended as indicated by HCFA in their March 4, 1998 Notice), HCFA has established that the essence of the bond will be to provide HCFA access to a pool of funds for the primary purpose of recovering any "overpayments", as defined and ultimately discovered by representatives for HCFA.

The question here is: what does this mean to the surety?

- Under some compensation agreements between HCFA's fiscal intermediaries and HHAs, payments

are based on estimates of the current year's billings which, in turn, are based on the previous year's costs taken from non-certified cost reports.

- HHA "cost reports" are not audited and/or accepted for 12 to 23 months following the fiscal year end for the HHA.

**"Overpayments" are the result of numerous reasons, other than fraud.**

- Errors made by the fiscal intermediaries in their payments and processing.
- An efficient HHA may have costs that beat the "estimates" made in establishing the payment schedule for their fiscal year. Because the HHA was an efficient operator, they must return the excess (overpayment) to HCFA.
- HCFA regulations for approved procedures and/or rates, are subject to changes and may be applied retroactively.

Note that none of these examples have anything to do with fraud. Note that many of the conditions impacting the status of "overpayments" have nothing to do with the quality, let alone the legitimacy, of an HHA. Note that the lag time from the point of action to the point of discovery is extremely long.

The items noted above have nothing to do with the form of the bond, or the numerous complaints about the regulations that were received by HCFA from the surety industry. These considerations deal only with the essence of the bond requirement. It becomes very apparent that the ability of anyone to accept the obligations of another, under these circumstances, is very, very risky! The credit decision to be made by members of the surety industry becomes very clear and very easy, **because they must be very conservative.**

In the RFA Impact Analysis HCFA concludes, "The majority of the HHA's will not be significantly affected by this rule" . We do not agree with that conclusion. **The use of a bond, the essence of which is a strict financial guarantee, could eliminate most small businesses from the home health care profession.**

To site another assumption in the HCFA analysis, reference is made to the influx of 450 new HHA's per year. The implication being made is that the influx of new HHA's will offset the loss of the current providers that may be the result of this bond requirement. That assumption has to be tempered by this requirement.

Regardless of the calculations to determine the funds mandated to meet the new capitalization requirements contained in HCFA's rule, if the applicant cannot obtain a bond, they will not qualify for the Medicare Provider Agreement. If it is going to be difficult for existing small businesses to qualify for this bond, consider the impact that this requirement will have on new applicants.

I do not believe that the goal of Congress in passing the surety bonding provision of the Balanced Budget Act of 1997 was to eliminate small business from the home health care profession. However, enforcement of these regulations will, at best, have a major negative impact on small business.

It should be noted that the technical changes to the HHA bonding regulations which HCFA said they intend to publish in the near future will address some of the concerns of the surety industry regarding cumulative liability and the ability of sureties to defend themselves against claims, which were very serious problems in the regulations as originally published. The notice that these changes will be made has allowed surety companies to begin the process of prequalifying and bonding HHAs, particularly larger, well capitalized firms. However, these revisions will not change the fact that the bond requirement remains a very strict financial guarantee. Nor will these changes alter the facts surrounding the nature of the home health care industry, nor, in our opinion, improve the ability of smaller, independent HHAs to obtain bonds as required under these regulations.

So, what effect will these bonding regulations have on fraud in Medicare? The answers vary.

- If sureties are allowed to accept collateral as an underwriting approach, these regulations give the fraudulent provider a license to steal.
- Management of the surety industry has an obligation to enhance and protect the investments of their shareholders. If small business is locked out of home health care, it is because the management of the surety industry has no other choice!
- There is no concurrence within the surety industry as to the information required to prequalify an HHA. Whatever information is accumulated by the surety industry will be varied in context and scattered about the industry. The efforts will be of little or no use to the authorities in fighting fraud.
- Expect the number of home health agencies to take a dramatic drop.
- Expect a drop in fraud. When you eliminate an estimated 80% of HHA's in the industry, you will certainly have some effect on the fraud in Medicare!
- Expect some improvement in the collection of overpayments. In the top 20% of the industry, HCFA should not have a problem in collection. However, within that spectrum of the industry there will be some financial failures, and there will be some recovery from surety companies of overpayments that are not recovered today.

These results come at a fairly high price. HCFA, in collaboration with members of the surety industry, estimate the annual surety bond premium cost to be between \$18,000,000 and \$20,000,000. **As a non-reimbursable cost under Medicare, the premium expense becomes a tax on HHAs, levied by the Health Care Financing Administration, for the primary purpose of being able to collect "overpayments", when discovered.**

Once published, we should know within 45 to 60 days the degree to which the revised regulations result in bonds being available to small independent HHAs. Should the economic impact of the bond be deemed as unacceptable, there are alternatives in the surety industry to be explored. The remainder of this statement offers some thoughts with respects to the services of the surety industry that may be more readily available, as well as more efficient in addressing the matter of fraud in Medicare.

The surety industry can offer their **prequalification services** of home health care agencies through a **Compliance Bond** -- similar to the bond used in Florida for their Medicaid program -- if the obligation is well designed and the requirement carries reasonable penal amounts. We submit that a joint effort of the surety industry, HCFA, the home health care industry and the Justice Department could develop the underwriting criteria and applications needed to find and eliminate a substantial portion of the fraudulent

operations currently impacting Medicare.

It is important to note that the underwriting associated with a Compliance Bond is substantially different than that for a strict financial guarantee as required by HCFA's regulations. The essence of Compliance Bond underwriting is to determine the qualifications of the HHA to comply with the rules and regulations governing home health care agencies, as mandated by the Medicare Provider Agreement. That would include licensing, adequate insurance, processing requirements, quality of care, as well as the payment of penalties associated with non compliance. In considering this alternative surety product, we suggest that the overall specifics of the prequalification process would be contained in a uniform application for completion by all HHA's.

We recommend that the application to be used for this bond should be designed in concert with HCFA, and then mandated by HCFA, to insure comparable steps for prequalifying all HHA's. The application form should contain a statement, to be signed by the applicant, acknowledging the fact that the information is not subject to confidentiality and that the surety is authorized to provide the information contained in the application to a representative of the Justice Department, if asked to do so. If it is possible to include such a provision in the regulations, we suggest that any falsification of the application should be classified as a felony, with incarceration as a penalty for violation.

The collateralization of these bonds should be illegal, by statute. An HHA that is guilty of fraud will be quite willing to provide collateral in exchange for a bond. The bond would legitimize their position with HCFA, and allow them to continue to extract dollars from Medicare via fraudulent schemes.

**Collateral would be a small price to pay for a "license to steal".** This is also precisely why any alternative, such as an escrow account or savings bonds would actually be counterproductive to the intent of the legislation contained in BBA'97.

To further this deterrent, the bond form should contain an affidavit, to be executed by the party signing the bond on behalf of the principal, which certifies that no collateral has been offered or accepted in the procurement of the bond. Falsification of that statement should be a felony offense, subject to imprisonment.

Once the prequalification of the existing HHA's has been completed, the surety industry would be left as the "gate keeper" for prequalification of the new entries into the Medicare reimbursement process.

Many members of the surety industry have made extensive studies of the home health care profession and, with their knowledge of the surety process, are certainly qualified to cooperate with the other identified parties in designing this process. In an all out push, the development of the HCFA application form and the prequalification process could be completed within 30 to 45 days. Anticipating acceptance by all parties, including HCFA, the surety industry, the home health care profession and the Justice Department, the surety industry could mount a training effort for producers and underwriters that could be completed in the "60 day comment period", following publication of the amended regulations. Within the following 60 days the HHA prequalification process could be completed.

There is a way...if we match the correct surety product to the home health care profession...and all work together.

**Is this a timely assault on fraud in Medicare?**

With the "weeding out" of the fraudulent and non-qualified providers, HCFA would be left with fewer

provider numbers to audit. The percentage of audits would increase, and the ability to target audits, based upon information that may be developed in the application process would improve the efficiency of that function of HCFA's fiscal intermediaries in addressing fraud.

One would reasonably expect that the inclusion of felony charges for the falsification of the forms provided, would in itself, cause some providers to reconsider either their position or their business practices.

The collection and management of the information by the surety industry would provide a data source for the Justice Department to improve the efficiency of their investigations. With the recent announcement made by HCFA on March 17th, of their intention to retain independent contractors to further the anti fraud initiative, the prospects of refined data being obtained via the bond application gives even greater meaning to this recommendation.

The large network of independent insurance agencies provides immediate and adequate access to the surety industry which would allow this process to proceed without undue hardship on the HHA's.

The surety industry can be quickly mobilized to perform the prequalification of the HHA's.

All at a cost of zero dollars to the federal government, since the cost of the bond is non-reimbursable under Medicare. (However, we do believe that this stipulation is blatantly unfair and tantamount to a "tax" being levied on HHAs, as we previously indicated.)

While the issue of **fraud** is the primary focus of this process, the reality of preserving the qualified and well run HHA's, owned and operated by **small business** is a secondary benefit of this approach. Conventional wisdom tells us that the industry cannot meet the demands of the elderly without the input of small business. **This is particularly true in rural America.**

A Compliance Bond of \$50,000 represents an adequate penalty to be certain that the surety underwriter does their job, and does it well. At an estimated cost of \$500 per provider, the expense is low enough to be absorbed by the average HHA.

We realize that the suggestion of using a Compliance Bond as a means of "weeding out" the field of Medicare providers neither addresses nor solves the problem of unpaid Medicare debt from the HHA's. However, to call upon an old saying, "An ounce of prevention is worth a pound of cure". If the existence and/or the uncollectibility of Medicare debt is a problem, then we suggest that the place to attack the problem is at the beginning of the payment cycle, and not 18 to 24 months after the fact. The fiscal intermediaries are and should be the "watch dogs" of the payment cycle. If they are not now held to a reasonable level of financial responsibility for their services, then they must be in the future.

I would like to close with the words of Representative Thurman when she introduced the surety bond provisions as part of BBA'97. The following is taken from the Congressional Record of April 24, 1997 regarding the Medicare Anti-Fraud Amendments Act of 1997 (Re: vol. 143, No. 50)

***We are offering this legislation to weed out unscrupulous providers in Medicare. The bill will not only protect beneficiaries and respectable providers, but also prevent the funneling of needed health care dollars into the hands of health care scam artists.***

***In the case of the State of Florida, we have had tremendous success in fighting fraud in the Medicaid program by requiring the service providers such as Durable Medical Equipment Suppliers, private***

***transportation companies, non-physician owned clinics and home health agencies, to post a \$50,000 surety bond in order to participate in Medicaid. The bonding requirement is no obstacle to legitimate providers, but presents a serious roadblock to Medicaid scam artists. Through the bond requirement, Florida has reduced the number of DME providers 62%, from 4,146 to 1,565, and home health agencies have decreased by 41% from 738 to 441; these reductions have no impact on patient care.***

***In fact, the surety bond requirement helped Florida to identify 49 DME providers who were using post office box numbers to bilk the Medicaid program.***

Clearly, Representative Thurman was focused on attacking the problem of fraudulent activity in the health care industry. With equal clarity, it is obvious that the State of Florida has derived a tremendous benefit from their surety bond requirement by eliminating an astounding number of either fraudulent or unqualified providers.

The surety product used in Florida was a Compliance Bond. There was a joint effort involving Medicaid, judicial authorities, and the surety industry. The results on the federal level even can be improved by enhancing the process.

If HCFA's bonding rule is revoked because of a misdirected objective when establishing in regulation the bond requirements called for by Congress, know that there are alternatives. This could be a unique opportunity to address the problems of fraud in Medicare, but it will call for some unprecedented cooperation between the government and private industry to establish and accomplish common goals to find and eliminate fraudulent operations.

It is certainly the desire of NASBP to see an effective implementation of the surety bond requirement mandated in BBA'97. However, we are concerned that the current regulations will have a serious impact on small business. We urge HCFA to monitor the impact of their current bond requirement and to understand there are alternatives within the surety industry that can be used to meet the intent of Congress and the needs of HCFA in controlling fraud in Medicare.

I pledge to make available the resources of NASBP to assist Congress and HCFA in this much needed effort to protect the integrity of our health system.